

# Social Security Administration

## Important Information



**THIS COVER LETTER IS FOR INFORMATION ONLY.  
DO NOT COMPLETE THE FOLLOWING PAGES.  
THIS IS NOT AN APPLICATION.**

**Our records show you may be eligible to get extra help paying for your prescription drugs.**

Soon, a new Medicare Prescription Drug program will take effect. The new program will give you a choice of prescription plans that offer various types of coverage.

You may be able to get extra help to pay for a part of your monthly premiums and co-payments related to the new Medicare Prescription Drug program—coverage of \$2,100 in extra help.

But before we can help you, **you must fill out the application, put it in the enclosed envelope, and mail it today.** Or you may complete an online application at [www.socialsecurity.gov](http://www.socialsecurity.gov) beginning July 1, 2005. We will review your application and send you a letter to let you know if you qualify for extra help. We also will send you information about the Medicare Prescription Drug program and tell you what you should do next.

If you need help completing the application, call Social Security at **1-800-772-1213** (TTY **1-800-325-0778**). You can find more information at [www.socialsecurity.gov](http://www.socialsecurity.gov).

If you need information about the new Medicare Prescription Drug program, call 1-800-MEDICARE (TTY 1-877-486-2048) or visit [www.medicare.gov](http://www.medicare.gov).

Mailing your application today will allow us to give you a quicker decision about whether you qualify for the extra help.

A handwritten signature in black ink that reads "Jo Anne B. Barnhart".

Jo Anne B. Barnhart  
Commissioner

# General Instructions for Completing the Application for Help with Medicare Prescription Drug Plan Costs



*To Provide Extra Help in Paying for Your Drug Expenses*

## A SPECIAL NOTE FOR (enter language) SPEAKING APPLICANTS:

Because we want to process applications as quickly and efficiently as possible, we are using application forms that can be read by computers. Unfortunately, our computers do not read (enter language), so you will need to fill out an English or Spanish language version of the application.

This form has been translated into (enter language) to assist you. However, you will need to enter your answers to each question on an English or Spanish application form. Please remember to sign the application form you have completed.

## THIS INSTRUCTION SHEET IS NOT AN APPLICATION FORM.

**Do you (or the person you are helping apply) have Medicare and Supplemental Security Income (SSI) or Medicare and Medicaid or does your state pay your Medicare premiums?**



If the answer is **YES**, **do not complete this application because you automatically will get the extra help.** You will receive another letter about how you will receive the extra help. If the answer is **NO** or **NOT SURE**, please complete this application. Please follow the following instructions and guidelines before completing this application. Complete all questions unless otherwise noted.

### How To Complete Your Application

- Use **BLACK INK** or a **#2 pencil**;
- Keep your numbers, letters and Xs inside the boxes;
- Do not use dollar signs when entering money amounts.  
The dollar sign is preprinted; and
- Cents can be rounded to the nearest whole dollar.

**EXAMPLE**

**Put an X in the box. DO NOT fill in or use check marks in boxes.**

	
<b>CORRECT</b>	<b>INCORRECT</b>

### If You Are Assisting Someone Else With This Application

Answer the questions as if that person were completing the application. You must know that person's Social Security number and financial information. Also, complete Section B on page 6.

### Completing Your Application

You may complete the online application at [www.socialsecurity.gov](http://www.socialsecurity.gov) or use the enclosed pre-addressed stamped envelope to return your completed and signed application to:

**Social Security Administration  
Wilkes-Barre Data Operations Center  
P.O. Box 1020  
Wilkes-Barre, PA 18767-9910**

Return the entire package in the enclosed envelope. Do not include any attachments. If we need more information, such as statements from financial institutions, we will contact you.

### If You Have Questions Or Need Help Completing This Application

You may call us toll-free at **1-800-772-1213**, or if you are deaf or hard of hearing, you may call our TTY number, **1-800-325-0778**.



**THIS DOES NOT ENROLL YOU IN THE  
MEDICARE PRESCRIPTION DRUG PROGRAM.**

A	B	C	D
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MI

**SUFFIX (Jr., Sr., etc.)**

## SOCIAL SECURITY NUMBER EXAMPLE

☐ Only you are applying. ☐ Both you and your spouse have Medicare and are applying on

\_\_\_\_\_

## MI

**SUFFIX (Jr., Sr., etc.)**

$$\square \square \square - \square \square - \square \square \square \square$$

If you put an ☐ in the **YES** box, you are not eligible for the extra help and you do not need to complete the rest of this application. You may still be eligible through your state Medicaid agency. However, if you want a decision, put an ☐ in the **NOT SURE** box. If you put an ☐ in either the **NO** or **NOT SURE** box, complete the rest of this application.



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4. Please enter the money amounts of bank accounts, investments or cash that either you, your spouse (if married and living together) or both of you own in the boxes below. Include items that either of you own with another person. (Include only the dollar figures, not the account number.) If you or your spouse (if married and living together) do not own an item listed, either separately, jointly or with another person, place an ☒ in the **NONE** box.

• Bank accounts (checking, savings and certificates of deposit)	<input type="checkbox"/> <b>NONE</b>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
• Stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	<input type="checkbox"/> <b>NONE</b>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
• Any other cash at home or anywhere else	<input type="checkbox"/> <b>NONE</b>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

5. Do you (or your spouse, if married and living together) own life insurance policies with a total face value of \$1,500 or more? Answer for you and for your spouse if your spouse lives with you. If you answered **NO** for both you and your spouse, go to question 6.

**SAMPLE**

YOU: ☐ **YES** ☐ **NO**  
SPOUSE (if living together): ☐ **YES** ☐ **NO**

If the answer for either you or your spouse is **YES**, how much money would you get if you turned in your insurance policies for cash right now? (This is not the face value of your policies. You may need to call your insurance company to help answer this question.) Enter the amount.

\$   ,    .

6. Do you expect to use money from any of the sources listed in questions 4 or 5 to pay for funeral or burial expenses for yourself (or your spouse, if married and living together)?

YOU: ☐ **YES** ☐ **NO**

SPOUSE (if living together): ☐ **YES** ☐ **NO**

7. Other than your home and the property on which it is located, do you (or your spouse, if married and living together) own any real estate?

☐ **YES** ☐ **NO**



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8. Your living situation may affect the amount of help you can get. Therefore, we need to know how many relatives who live with you (and your spouse, if married and living together) depend on you or your spouse to provide at least one-half of their financial support. Relatives may include anyone related to you by blood, marriage or adoption.

How many relatives who live with you and your spouse depend on you or your spouse to provide at least one-half of their financial support? **Do not include yourself or your spouse in this number.** (Place an ☒ in only one box.)

☐ **NONE**   ☐ **1**   ☐ **2**   ☐ **3**   ☐ **4**   ☐ **5**   ☐ **6**   ☐ **7**   ☐ **8**   ☐ **9 or more**

9. If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **total monthly income**. **If the amount changes from month to month, enter the average monthly income for the past year for each type** in the appropriate boxes. Do not list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. If you or your spouse do not receive income from any of the sources listed below, place an ☒ in the **NONE** box.

• Social Security	We will use the amount in our records.	
• Railroad Retirement	<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>	
• Veterans	<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>	
• Other pensions or annuities (Do not include money you receive from any item you included in question 4.)	<input type="checkbox"/> <b>NONE</b>	\$ <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
• Other income not listed above, including alimony, net rental income, workers' compensation (Specify): _____	<input type="checkbox"/> <b>NONE</b>	\$ <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>

10. Have any of the amounts you included in question 9 decreased during the last two years?

☐ **YES**   ☐ **NO**

11. Does anyone provide or help you (or your spouse, if married and living together) pay for any of the following household expenses — food, mortgage, rent, heating fuel or gas, electricity, water and property taxes? (Do not include food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels, or help with medical treatment and drugs.)

☐ **YES**   ☐ **NO**

If you put an ☒ in the **YES** box, enter the monthly amount, or if the amount changes from month to month, enter the average monthly amount for the past year.

\$ ☐☐ , ☐☐☐☐ . ☐☐



DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

- If you are single, divorced, separated or a widow(er) and have not worked in the last two years, skip questions 12 – 16 and go to page 6.
- If you are married and living with your spouse and neither of you have worked in the last two years, skip questions 12 – 16 and go to page 6.

12. What do you expect to earn in wages before taxes **this year**?

YOU: ☐ NONE \$   ,    .

SPOUSE (if living together): ☐ NONE \$   ,    .

13. If self-employed, what do you expect your net earnings or loss to be **this year**?

YOU: ☐ NONE \$   ,    .

SPOUSE (if living together): ☐ NONE \$   ,    .

Put an ☒ here if you or your spouse expect a net loss. YOU: ☐ SPOUSE (if living together): ☐

14. Have the amounts you included in questions 12 or 13 decreased in the last two years?

☐ YES ☐ NO

15. If you (or your spouse, if married and living together) recently stopped working or plan to stop working, enter the month and year.

**EXAMPLE**

For January – September, put a zero (0) in the first box. May 2006 should read:

0	5	2	0	0	6
M	M	Y	Y	Y	Y

YOU:        
M M Y Y Y Y

SPOUSE (if living together):        
M M Y Y Y Y

- If you are single, divorced, separated or a widow(er) and 65 or older, skip question 16 and go to page 6.
- If you are married and living with your spouse and both you and your spouse are 65 or older, skip question 16 and go to page 6.

16. Do you (or your spouse, if married and living together) have to pay for things that enable you to work? We will count only a part of your earnings toward the income limit if you work and receive Social Security benefits based on a disability or blindness and you have work-related expenses for which you are not reimbursed. Examples of such expenses are: the cost of medical treatment and drugs for AIDS, cancer, depression, or epilepsy; a wheelchair; personal attendant services; vehicle modifications, driver assistance or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

YOU: ☐ YES ☐ NO

SPOUSE (if living together): ☐ YES ☐ NO



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## Signatures

I/We understand that by submitting this application I am/we are declaring under penalty of perjury that I/we have examined all the information on this form and it is true and correct to the best of my/our knowledge. I/We understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both. I/We understand that the Social Security Administration (SSA) will check my/our statements and compare its records with records from Federal, State, and local government agencies, including the Internal Revenue Service to make sure the determination is correct. By submitting this application I am/we are authorizing SSA to obtain and disclose information related to my/our income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my/our wages, account balances, investments, insurance policies, benefits, and pensions. **Please complete Section A. If you cannot sign, a representative may sign for you. If someone assisted you, complete Section B as well.**

### SECTION A

Your Signature:	Your Spouse's Signature:	Phone Number: (     )     —	
Your Home Street Address:		Apt. #:	
City:		State:	Zip Code:
Your Mailing Street Address (if different from home address):		Apt. #:	
City:		State:	Zip Code:

If you recently changed your address, put an ☒ here: ☐

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

Print First Name:	Print Last Name:	Phone Number: (     )     —
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### SECTION B

If you are assisting someone else, place an ☒ in the box that describes who you are and provide your daytime phone number and address.

<input type="checkbox"/> Family Member	<input type="checkbox"/> Attorney	<input type="checkbox"/> Other Advocate	<input type="checkbox"/> Other Specify: _____
<input type="checkbox"/> Friend	<input type="checkbox"/> Agency	<input type="checkbox"/> Social Worker	_____

Print First Name:	Print Last Name:	Phone Number: (     )     —	
Street Address:		Apt. #:	
City:		State:	Zip Code:



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## **Privacy Act / Paperwork Reduction Notice**

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Section 1860 D-14 of the *Social Security Act* authorizes the collection of information requested on this form. The information you provide will be used to enable the Social Security Administration to determine if you are eligible for help paying your share of the cost of a Medicare Prescription Drug Plan. You do not have to give us the information requested. However, if you do not provide the information, we will be unable to make an accurate and timely decision on your application. We may provide information collected on this form to another Federal, State, or local government agency to assist us in determining your eligibility for the extra help or if a Federal law requires the release of information.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

**SAMPLE**

Paperwork Reduction Act of 1995. This form meets the requirements of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless you display a valid Office of Management and Budget control number. We estimate that it will take about 35 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: Social Security Administration, 1338 Annex Building, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

**SEND THE COMPLETED FORM TO US AT THE ADDRESS SHOWN ON THE ENCLOSED PRE-ADDRESSED ENVELOPE:**

**Social Security Administration  
Wilkes-Barre Data Operations Center  
P.O. Box 1020  
Wilkes-Barre, PA 18767-9910**